Document 2a

MEDICAL RECORD — **CHRONOLOGICAL RECORD OF MEDICAL CARE**

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION *(Sign each entry)*
5-10-04	ADMIN NOTE: Pt being discharged from BOP to "the
1015	street." Needs release meds:
	RELEASE MEDICATIONS 1. Sulindac* 150mg* tpo BID. #28 NR
	2. Albuterol 2 puffs QID #1 NR
	3. Azmacort 3 puffs (three) BID #1 NR
	4. Ranitidine 150g tpo BID #28 NR
	* Pt has Cerebral Palsy, Scoliosis, Asthma, HERD.
	Reviewed By: V. Geza, PharmD
	Steven Labrozzi, PA-C Physician Assistant

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT
			FCI McKean
SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR	

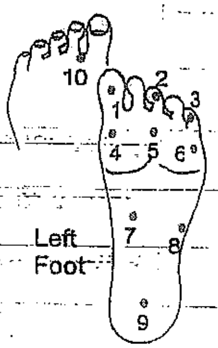
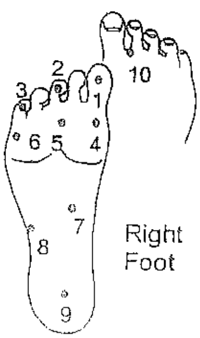
PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.)*

REGISTER NO.	WARD NO.

MANSO, Ahmad 09105-055

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION *(Sign each entry)*

MEDICAL RECORD | CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT. TREATING ORGANIZATION (Sign each entry)
	CLINIC(S): ( ) Cardiac ( ) Hypertension ( ) Diabetes ( ) Infections ( ) Endocrines ( ) Lipid ( ) Pulmonary ( ) Mental ( ) Neurology ( ) Ortho ( ) General ( ) Other:
4/21/04 1005	SUBJECTIVE: (Chief Complaint) See c/o pain elbow back; (L) side. can't sleep (knee) received Naprosyn no help. Asthma
	Med. Compliance: estomago - O/C Stable
	OBJECTIVE: (Review System) Age: 37 Sex: Male Race:
	B / P: 90/70 P: 60 Wt: 160 T: R / R: SO2%: Peak Flow:
Diabetic foot Screen Test Steps	HEENT: O/C Last Op / Opth. Eval.:
 Left Foot	Heart: O/C
	Lungs: Clear — reflexes 190 / 150 / 150 very poor effort
	Abdomen: (-) mov
	Genital / Rectal: (L) Shoulder
	Extremities:
	Neuro: he been Hx CTS (L) elbow
	Recent Lab Results: wrist. ↓ ROM (L) Shoulder
Diabetic foot Screen Test Steps	ASSESSMENT(S):
 Right Foot	DSM IV Classification
	Axis I:
	Axis II: Hx CTS [illegible]
	Axis III: Cerebral Palsy Asthma GERD
	Preventive Care: Diet: O/C Exercise: Walk
	Tobacco Use: no Medication Side Effects: no

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART. / SERVICE	RECORDS MAINTAINED AT FCI McKean
SPONSOR'S NAME	SSN / ID NO.	RELATIONSHIP TO SPONSOR	

PATIENTS IDENTIFICATION: (For typed or written entries give: Name – last, first, middle; ID No. or SSN; Sex; Date of Birth, Rank / Grade)

Abimael Manso

REGISTER NO. 09105-055 | WARD NO.

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
STANDARD FORM 600 (REV. 6-97)
Prescribed by GSA / ICMR 000003

DATE | SYMPTOMS, DIAG[redacted]REATMENT. TREATING ORGAN[redacted] (Sign each entry)

Pain Level: 1 2 3 4 5 6 7 8 (X) 9 10

PLAN:

(4) Amox

Patient Education:

( ) Discussed Test Results ( ) Discussed Tx Plan

(-) Etiology, Complications, Prognosis, Prevention

( ) Diet, Diabetic / Cardiac / Disease, Lifestyle Changes ( ) No Smoking

( ) Medication Dosage / Administration / Compliance / Side Effects

( ) Patient Understood Topics ( ) Instructed If Problems

or if running our of medication, should sign up for sick-call or send cop out.

Diagnostic Studies: ( ) CBC / Dif ( ) U / A ( ) LFT ( ) Chem. Profile ( ) Lipids ( ) HgAlc
( ) PSA ( ) Viral Load ( ) CD4 ( ) Toxo Igg. ( ) Hepatitis Panel
( ) CXR ( ) EKG ( ) Others:

Consultations: ( ) Optometrist ( ) Ophthalmologist ( ) Orthopedic Surgeon
(-) Others:

Referral for Vaccination: ( ) Influenza ( ) Pneumococal ( ) Other:

Return to Clinic for routine Follow-Up on: 3mo

Treatments(s):

(Change) Sulendac 150mg 1 po Bid #20 RF
Albuterol Tiuff Bid #1 RF2
Azmacort 2 puffs Bid #1 RF2
Ranitidine 150 mg 1 po Bid #60 RF-2

Reviewed By:
V. Geza, PharmD

H. BEAM, MD
FCI McKEAN

STAND[illegible] FORM 600 (REV. 6-[illegible]

000004

MEDICAL RECORD — **CHRONOLOGICAL RECORD OF MEDICAL CARE**

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION (Sign each entry)
4-13-04	Inmate Rec'd 2 pp. Medical Records T. Petruzzi HIT
1030	T. Petruzzi, HIT

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT
			SCI Mercer
SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR	

PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.)*

Mansa-Diaz, Abniel

REGISTER NO. 09105 055

WARD NO.

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION *(Sign each entry)*

MEDICAL RECORD — **CHRONOLOGICAL RECORD OF MEDICAL CARE**

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION (Sign each entry)
4/8/04 1030	(S) -Rev skin ulcers on inner thighs (see 4-1-04). Pt states: ulcers are better... now has oozing.
	-Requests Medical Note for transfer from 1D man to 2 man cell... due to frequency of being "bumped" by all the men in his cell.
	(O) Pt has CP + scoliosis: gait + carriage + M/S problems are commensurate c that Dxs
	M/S: (+) atrophy of (L) arm with apparent inability: - to abduct at shoulder > 45° - to forward abduct > 45° - to pronate, supinate (L) arm
	(+) pain to palpation of entire (L) scapula, acromion, lateral (L) clavicle, bicipital groove (no pain at biceps). + pain at (L) trapezius.
	Poor to little muscle strength (L) Arm / hand
	Neuro: DTR: Bicep tendon / Brachioradialis extreme hyperreflexia at (L) arm Normal response at (R) arm
	Vibration sense: intact thru-out (R) arm (L) arm: Pt claims lack of vibration sense at all sites (shoulder-acromion, elbow-olecranon, all PIPs, MCPs, DIPs) except some (decreased) vibration sense at 3rd + 4th (L) MCPs.
	Sensations to light touch: (L) arm: Pt claims lack of sensations at all aspects (shoulder, biceps, forearm, elbow, wrists, fingers, finger tips) except at proximal-medial forearm.
Servor sl 4-8	(R) SKIN (inner thighs) Erosive lesions of 4-01-04... are healed c new pink epidermis covering sites. - some macular scarring
	CONT'D

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT
			FCI McKean
SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR	

PATIENT'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.)

REGISTER NO.	WARD NO.

MANSO-Diaz, Abimael
09105-055

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION (Sign each entry)
4/8/04	(A) 1. - Erosive Stas Lesions, inner thighs, resolved
1030	2. Tinea Cruris
Cont'd	3 CP, Scoliosis
	(P) 1. Tinactin 1% Cream * Apply very small amt to cleaned + dried areas of groin BID #1 R×3
	* Pt claims lack of Commissary Funds
	2. Pt Ed: Dx, Tx, meds. & pt understands hygiene
	3. FU prn. S/C.
	4. Medical "Transfer" to 2 room cell if approved by MD. *
	A. Labrozzi Steven Labrozzi, PA-C Physician Assistant
4/8/04	ADMIN NOTE → * RE: transfer to 2 man cell ---
1130 error sl 4-8 1130	1) Request deferred by Dr. Beam & Health Services Administrators
	2) Request denied at this time by AHSA.
	3) Patient informed of decision.
	Steven Labrozzi, PA-C Physician Assistant
4/8/04	Admin Note: Pharmacy
1300	I'm not considered indigent & can be refer error 4/8/04 Referred to commissary for OTC medications.
	Reviewed By: V. Geza, PharmD

NSN 7540-00-63[illegible]

AUTHORIZE[D]

MEDICAL RECORD | **CHRONOLOGICAL RECORD OF MEDICAL CA[RE]**

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sig[n each entry])
	Ⓢ c/o bleeding from genitals × 17 days
4/1/04 1030	PAIN = HA & regional pain @ 5/10 burning. Denies trauma to area. Denies knowledge of precipitating factors [...] been given & forced to use used-underwear after D/C from S[...]
	Ⓞ NAD T = 97.5°F Genitals ⊕ 1 inch erosive lesions, in[...] thighs, bilat. c̄ exposure subdermal / ~~skin~~ tissue (error V-1 [illegible])
	Ⓐ SKIN ULCERS R/o cellulitis
	Ⓟ 1. Keflex 500 mg i po QID × 5 days #20 NR
	2. BACITRACIN OINTMENT Apply HA QD-BID #1 NR
	3. Clean c̄ Betadine. Dress c̄ Bacitracin & Bandaid. Pt to re-dress QD. Supplies given
	4. ED: Tx, Dx, Meds. Pt understands
	5. R/C in 7 days: Lev
	Reviewed By: V. Geza, PharmD [signature] — [signature] Steven Labrozzi, PA-[C] Physician Assistant
4/6/04 0700	ADMIN NOTE: C&S Results: (see 4-1) ~~error [illegible] 4/6/04 MIXED SKIN FLORA~~ — STAPH au[reus] [...] to 1st [...] cephal[...] → Pt on Keflex.
	[signature] Steven La[brozzi] Physicia[n Assistant]

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE
SPONSOR'S NAME	**SSN/ID NO.**	**RELATIONSHIP TO SPONSOR**

PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.)*

REGISTER NO. 09105-

MANSO-Diaz
Abimael

CHRONOLOGICAL REC[ORD]
Medica[l Record]
STANDARD FORM
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-9.[...]

CHRONOLOG[ICAL] YMPTOMS, DIAGNOSIS, TREAT[MENT]
[bleed]ing from genitals
HA & regional pain
trauma to area. Denies k[...]
given & forced to use use[d...]
T = 97.5°F Genitals
[UL]CERS [Cel]lulitis
[Kef]lex 500 mg i po
[BAC]ITRACIN OINTMENT App[ly]
[...] c̄ Betadine. Dress
[P]t to re-dress QD Su[pplies]
Tx, Dx, Meds. P[t]
in 7 days: Lev
[Reviewed B]y: [...]arm[D]
TE: Results: (see 4-1) MIXED S → Pt on K
STATUS SSN/ID NO.
[For typed o]r written entries, give: Name - last, first, m[iddle...] Rank/Grade.)

MEDICAL RECORD — **CHRONOLOGICAL RECORD OF MEDICAL CARE**

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION *(Sign each entry)*
3/15/04	Inmate Rec. & Trg. Medical Records J. McCoy HIT T. Petruzzi, HIT
0730	

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT
			FCI McKean
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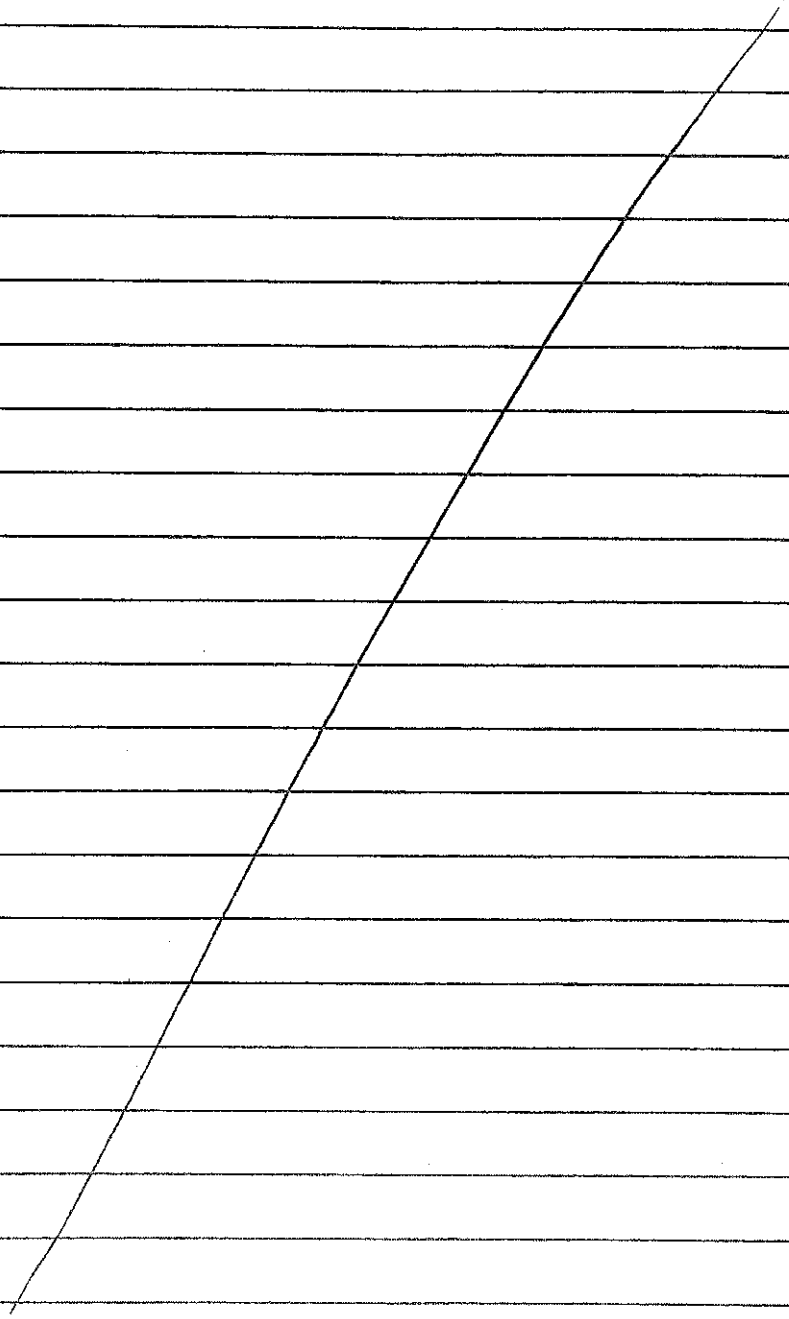
PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.)*

REGISTER NO. 09105-055 | WARD NO.

Manse - Diag. Abnormal

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION *(Sign each entry)*



MEDICAL RECORD — **CHRONOLOGICAL RECORD OF MEDICAL CARE**

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION (Sign each entry)
1-26-04 ③ 0905	C/o "spinal problem" x 10 yrs since coming to this facility; paralysis x 30 min in lower extremities upon arising from bed ("tail bone down") HAS mattress is too thin. HAS GONE TO WARDEN, who intervened for better mattress with no results from correctional staff. See also Dr. Beam's note
④	Referred.
Ⓐ	CP, scoliosis (see problem list)
Ⓟ	1. Check c Clinical Director, correctional staff re: mattress issue.
	2. Pt understands.
	L Hay
	ADDENDUM:
	C/o strong burning pain 7/10/10 waves of pain every day all day feels like bones are grating from back to lower legs.
	- IS already ON Lioresal and Naproxen.
	- worse when upright, walking decreased when lays down, provided mattress is soft.
	- REFUSES PILL LINE MEDS.
	Per Dr. Beam: No other pain meds available until Pt willing to come to pill line for Elavil.
	Mattress issue has already been forwarded to unit manager (Mr. Kinderwater).
	L Hay

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PATIENT'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.)

REGISTER NO.	WARD NO.

Munso, Ahmed 09105-055

DW

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
STANDARD FORM 600 (REV. 6-97)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-9.202-1

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION (Sign each entry)
1-27-04 1400	ADMIN NOTE Mr. Kinderwater, Pt's ward manager, reports that IM has TWO mattresses on his bed. Mr. K will give IM an old-style fabric mattress (if one is available) if the IM so requests. In any event, ~~the mattress issue is now a~~ correctional issue, & not a health services matter.
3/11/04 1400	(S) ~~EMERGENCY~~ Pt c/o CP c/o PAIN 2° to being in SHU, being called frequently, sleeping on floor.. c/o PAIN: lower back, Left neck, Left scapula, He has no medication: Naproxen was confiscated Naproxen did not help very much Want (L) arm in flexed position +5/10 .... now +8/10
	(O) Pt holding arm (Left), flexed and against anterior torso Pt in wheelchair (brought to HSU in ~). (+) pain to palpation of (L) trapezius, scapula, (L) neck. Obvious CP: atrophy of limbs, distorted posture
	(A) CP c exacerbation of pain. GERD.
	(P) 1. Sling x 2 wks only 2. Double Mattress.... request given to Ellen McNich. 3. Naproxen: Please re-issue Rx 162359 4. Zantac: Please re-issue Rx 162361 5. Albuterol " " " 162362 6. Azmacort " " " 162360 These were all confiscated when IM thrown into SHU, & never given back to him. 7. Pt understands Tx plan RTC PRN
	Steven Labrozzi, PA Physician Assistant

MEDICAL RECORD — CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE | SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION (Sign each entry)

CLINIC(S): ( )Cardiac ( )Hypertension ( )Diabetes ( )Infectious ( )Endocrine

( ) Lipid ( )Pulmonary ( )Mental ( )Neurology ( )Ortho ( )General

1/22/04 1240 ( )Other: Asthma Cerebral palsy, Scoliosis

SUBJECTIVE: (Chief Complaint) OSED

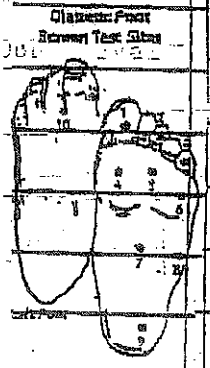
hurts in back, TO (+) for, hard to walk

walking (no one wants to push wheelchair)

Baclofen x 2 mo - no help

OBJECTIVE: (Review System) Age: 37yrs Sex: Male Race:

B/P: 120/70 P: 70 Wt: 155 T: R/R: SO2%: Peak Flow:



HEENT: WNL Last Op/Opht. Eval:

Heart: RRR scoliosis CVA TO L mid Thorac

Lungs: Clear flexion CTX LUE WIST

Abdomen: Soft NT elbow -

Genital/Rectal: slight spasm CGT. FROM

Extremities:

Neuro: ambulates WNL 210

Recent Lab Results: 200

240

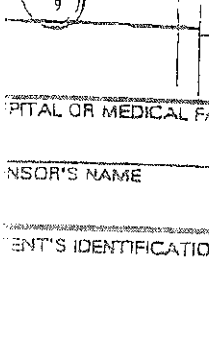
ASSESSMENT(S):

DSM IV Classification

Axis I:

Axis II:

Axis III: CP, Asthma, Hyperten. Scoliosis



Preventative Care: Diet WNL Exercise walks

Tobacco Use? yes Medication Side Effects: no

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT
			FCI McKean
SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR	

PATIENT'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.)

REGISTER NO. 07705-017 WARD NO.

Abdominal Wounds

DATE | SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION (Sign each entry)

Pain Level: 1 2 3 4 5 6 7 8 9 10 (15)

PLAN:

Patient Education:

(✓)Etiology, Complications, Prognosis, Prevention ( )Diet, Diabetic/Cardiac/ Disease, Lifestyle Changes (✓)No Smoking (✓)Medication Dosage/Administration/ Compliance/Side Effects (✓)Patient Understood Topics ( )Instructed if problems or if running out of medication, should sign up for sick-call or send cop out.

Diagnostic Studies: ( )CBC/Diff ( )U/A ( )LFT ( )Chem Profile ( )Lipids ( )HgAlc ( )PSA ( )Viral Load ( )CD4 ( )Toxo Igg. ( )Hepatitis Panel ( )CXR ( )EKG ( ) Others:

Consultations: ( )Optometrist ( )Ophthalmologist ( )Orthopedic Surgeon ( )Others: Ha Baclofen 10mg tid. Then

Voltaren 50mg tid x 1wk 50mg Bid x 1wk Then PC

Referal-for Vaccination: ( )Influenza ( )Pneumococal ( )Other:

Return to Clinic for routine Follow-Up on:

Treatment(s): Albuterol 2 puff Bid #1 RF2

Aggrecort 2 puff Bid #1 RF2

Naproxyn 550mg po Bid #30 RF1

Ranitidine 150mg po Bid #60 RF2

Reviewed By:
V. Geza, PharmD

AL BEAM, ML
EGR McKEAN

000016

STANDARD FORM 600 (REV. 6-97) BACK

FPI, LEX Printed on Recycled Paper

NSN 7640-00-634-4176 — AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD — **CHRONOLOGICAL RECORD OF MEDICAL CARE**

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION (Sign each entry)
12-17-03 1035	Int/Ac physical accomplished. B. Doyle NP-C
12-17-03 1035	S: Pt cerumen (L) ear incidental finding during physical exam. No c/o.
	O: NAD. (R) ear: canal clear, TM intact; (L) ear: c cvk brown wax in canal, TM not observed. T 97.
	A: cerumen impaction (L) ear
	P: Debrox #1, instill 3-5 gtts. q PM x 5 days, RTC for f/u x 5 days and p.r.n. Pt understands. Pt education re: ear gtts. B. Doyle NP-C
	Reviewed By V. Geza, PharmD
12-22-03 0900	S: Pt cerumen impaction (see 12-17)
	O: NAD
	A: cerebral Palsy / Scoliosis. S/P cerumen impaction (resolved)
	P: 1. Naprosyn - 550 mg TPO c food/milk BID. Do not skip doses. #20 Rx3
	2. Soft Shoe Pass x 6 months
	Reviewed By V. Geza, PharmD — Steven Labrozzi, PA-C Physician Assistant

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT
			McKean
SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR	

PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.)*

REGISTER NO.	WARD NO.
09165-155	

Marco Diaz, Attorney

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION *(Sign each entry)*

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION *(Sign each entry)*
12/17/13	⊕ Asthma, c/p – pt in clinic, lower limb,
1400	med management
	Rx (1) Zantac 150mg IT HS #60
	(2) Albuterol inhaler 2 puffs QID PRN #1
	(3) Azmacort inhaler 2 puffs QID #1
	(4) Hold celebrex, Bactrim for now

Reviewed By:
V. Geza, PharmD

D. Olson, MD
Clinical Director

NSN 7540-00-634-4176 AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **CHRONOLOGICAL RECORD OF MEDICAL CARE**

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION *(Sign each entry)*
12-16-03 1305hr INTAKE	37 y/o H ♂ c̄ mult. Medical Problems ⊕ disabilities – incl. CP/scoliosis ⊕ GERD, Asthma, ⊕ adjustment D/O. c̄ Medication
	[signature] PA-C Robert E. Piotrowski, PA-C FCI McKean
	Ref Pills (x3) 12/16/03
12/16/03 1305hr	Chronic Medication Use MDI ⊕ Pills. [illegible] MDI (x2) c̄ Patient – Order Per Intake Form Chronic Meds x 1 mos. supply
	– Referral CCC
	– Scripts
	1.) Albuterol MDI @ ii Puff PO PRN Q4H #1 ø Ref
	2.) Triamcinolone MDI @ ii Puff PO TID (0600/1500/2100) #1 ø Ref
	3.) ZANTAC 150 mg @ ii PO QHS #60 ø Ref
	4.) BACLOFEN 10 mg i PO TID (0600/1500/2100) #90 ø Ref
	5.) Celebrex 200 mg i PO QD #30 ø Ref.
	[signature] Robert E. Piotrowski, PA-C FCI McKean

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT
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PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.)*

REGISTER NO. 09105-055 | WARD NO.

Manso, Abimael

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record

STANDARD FORM 600 (REV. 6-97)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-9.202-1

MEDICAL SUMMARY OF FEDERAL PRISONER/ ALIEN IN TRANSIT

U.S. Department of Justice

TB Clearance ☒ Yes ☐ No

1) PPD Completed: 11/21/03
Date

Results: Ø

2) CXR Completed: ______
Date

3) Health Authority
Clearance: [illegible]
CR 12/16/03
Sign Date

Note:
Dates listed above must be within one year of this transfer

United States
11/18/2003 M 11/25/1966

Manso-Diaz, Abimael
09105055
INS HSD BUFFALO

Destination: Ø

Non-medical

Dist. Name: WNY

Dist. #

Date in Custody:

II. Current Medical Problems

1. Cerebral Palsy
2. Scoliosis 2nd to C.P.
3. GERD.
4. Chronic Asthma
5. Allergy: ASA
6. Adjustment D/o.

Medication	Dose	Route	Medication Required For Care En Route — Instructions For Use (Include proper time for Administering)	Stop
Baclofen 10 mg	i	po	i po TID 0600 1500 2100	
Zantac 150 mg	ii	po	ii tabs = 300 mg po HS	
Celebrex 200 mg	i	po	i po qd	
Albuterol inhaler	2 puffs	po	q4h prn.	
Triamcinolone MDI	2 puffs	po	TID 0600 1500 2100	

Additional Comments:

III. SPECIAL NEEDS AFFECTING TRANSPORTATION

Is prisoner medically able to travel by BUS, VAN or CAR? ☒ Yes ☐ No If no, Why not?

Is prisoner medically able to travel by airplane? ☒ Yes ☐ No If no, Why not?

Is prisoner medically able to stay overnight at another facility en route to destination? ☒ Yes ☐ No If no, Why not?

Is there any medical reason for restricting the length of time prisoner can be in travel status? ☐ Yes ☒ No If yes, state reason:

Does prisoner require any medical equipment while in transport status? ☐ Yes ☒ No If yes, What equipment?

Sign & Print Name- Certifying Health Authority: Cindy M. [illegible] Licensed Practical Nurse

Phone Number: 585-344-5168

Date Signed: 12/16/03

Form USM-553
(Est. 6/98)

Original—Upon Transfer

000021

CLINICAL RECORD | **LABORATORY REPORTS**

ATTACH 3D REPORT ALONG HERE ↑ AND SUCCEEDING ONES ON ABOVE LINES

ATTACHING MARGIN

Manso-Dy Abimael
09105-055

FCI McKean
P.O. Box 5000
Bradford, PA 16701

10:50

Enter in above space PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE

URINALYSIS

URGENCY: ☐ ROUTINE ☑ TODAY ☐ PRE-OP ☐ STAT

SPECIMEN/LAB RPT NO

PATIENT STATUS: ☐ BED ☐ AMB ☑ OUTPATIENT ☐ NP ☐ DOM

SPECIMEN SOURCE: ☑ ROUTINE ☐ OTHER (Specify)

PATIENTS MED. RECORD

REQUESTING PHYSICIAN'S SIGNATURE: Dr. Beam

REPORTED BY: S. Czekai, Med Tech. (TECH) MD

DATE: 12/23/03

LAB. ID NO.

REMARKS

TEST(S)	SPECIMEN TAKEN	RESULTS
DATE	12/23/03	
TIME	10:10 A.M.	
REQUESTED	[X]	
ROUTINE	✓	
COLOR		yellow/clear
SPECIFIC GRAVITY		1.015
UROBILINOGEN		normal
OCCULT BLOOD		neg
BILE		neg
KETONES		neg
GLUCOSE		neg
PROTEIN		neg
pH		7.5
MICROSCOPIC		
WBC		
RBC		
EPITH CELLS		
CASTS: WBC		
CASTS: RBC		
CASTS: HYALINE		
CASTS: GRANULAR		
BACTERIA		
CRYSTALS		
MUCUS		
NITRITE		neg
Leukocytes		neg
BENCE-JONES PROTEIN		
HEMOSIDERIN		
HCG		

Reviewed by E. Olson, MD
Date: 12/31/03

URINALYSIS
Standard Form 550 (Rev. 4-77)
General Services Administration and Interagency Committee on Medical Records FIRMR (41 CFR) 201-45.505
550-107

ATTACH ALL TEST REPORTS TO THIS SHEET

PATIENT'S IDENTIFICATION (For typed or written entries give: Name—last, first, middle; grade; date; hospital or medical facility)

Manso Abimael

REGISTER NO. 09105-055

WARD NO.

LABORATORY REPORTS
Standard Form 514
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-45.505
October 1975 514-109

GPO : 1996 O - 169-517

U.S. MEDICAL CENTERS FOR FEDERAL PRISONERS
Laboratory, 1900 W. Sunshine
SPRINGFIELD, MISSOURI 65808
(417) 862-7041

*** SENSITIVE-LIMITED OFFICIAL USE ***
FINAL REPORT

Register Number	: 09105-055	Age	: 37yr
Name	: MANSO-D, ABIMAEL	Sex	: M
Location	: MCK	Accession Number	: 3100
Admit. Physician	: BEAM, MD		
Order. Physician	: BEAM, MD		
Collected	: 04/01/04 @ 10:00		

Test	Result	Flag	Reference Range/Units	Tech
MHIV-Ab	Negative		Negative	CK
	DO NOT REMOVE REPORT FROM PATIENT CHART			

Release

S. Czekai, Lab Tech

REVIEWED BY
Lt. BEAM, MD
IRCI MCKEAN
4/12/04

Legend
LO=Low AL=Alarm Low EL=Elevated Low HI=High AH=Alarm High EH=Elevated High AB=Abnormal

Name	: MANSO-D, ABIMAEL	Location	: MCK
Register Number	: 09105-055	Page	: 1 of 1
Printed	: 04/06/2004 @ 12:00		

LabCorp
Laboratory Corporation of America

Specimen #	Typ	Primary Lab	Report Status	
092-989-5694-0	S	CB	Final	Pg 1

Additional Information
Time 1130
SWAB
SRC-DRAINAGE THIGH LESIONS
CD- AET37806845

Clinical Information: DOB: 11/25/66

Patient Name	Sex	Age (Yr/Mo)
MANSO DIAZ, ABIMAIL	M	037/04/07

Pat. Addr.

Physician ID	Patient ID
LABROZZI S	09105-055

Account: FEDERAL CORRECTIONAL INSTITUTE 37806845
MCKEAN COUNTY
RT 59 & BIG SHANTY ROAD
LEWIS RUN, PA 16738
814-362-8900

Date Collected	Date Entered	Date Reported	
04/01/04	04/02/04	04/04/04	0859

TESTS	RESULT	FLAG	UNITS	REFERENCE INTERVAL	LAB
Aerobic Bacterial Culture	Final report				CB
Result 1	Staphylococcus aureus				CB
Moderate growth					
Antimicrobial Susceptibility					CB

***** S = Susceptible; I = Intermediate; R = Resistant *****
MICS are expressed in micrograms per mL

Antibiotic	RSLT#1	RSLT#2	RSLT#3	RSLT#4	LAB
Amoxicillin/CA	=S				CB
Ampicillin/Sulbactam	=S				CB
Cefazolin	=S				CB
Ciprofloxacin	=S				CB
Clindamycin	=S				CB
Erythromycin	=R				CB
Gentamicin	=S				CB
Levofloxacin	=S				CB
Oxacillin	=S				CB
Penicillin (Staph.)	=R				CB
Rifampin	=S				CB
Tetracycline	=S				CB
Trimeth-Sulfa	=S				CB
Vancomycin	=S				CB

Lab: CB LabCorp Dublin Director: Rose Goodwin, MD
6370 Wilcox Road Dublin, OH 43016-1296

For inquiries, the physician may contact: Branch: 412-937-1808 Lab: 614-889-1061
Last Page of Report

ON Keflex 4-6-04
Steven Labrozzi, PA-C
Physician Assistant

4/5/04 Sickal, MT
Sickal, Med Tech.

U. S. [redacted]ICAL CENTER FOR FEDERAL PR[redacted]NERS
[redacted]RATORY, 1900 W. SUNSHINE
SPRINGFIELD, MISSOURI 65808
(417) 862-7041, EXT. 454

FINAL REPORT

Register Number: 09105-055
Name : MANSO-D, ABIMAEL
Location : FCI MCKEAN (MCK)
Physician : BEAM, MD
Collection Date: 12/23/2003
Collection Time: 10:10
Tests Ordered: CBC; RPR

Age : 37
Sex : M
Accession Number: 3754
"X" if Complete : [X]

Test Name	Result	Flag	Reference Range			Tech
Collection Cmt.	.					
CBC						
White Blood Cell	6.9		10^3/uL	4.3	- 11.1	JE CK
Red Blood Cells	4.78		10^6/uL	4.46	- 5.78	JE CK
Hemoglobin	14.2		g/dL	13.6	- 17.6	JE CK
Hematocrit	43.3		%	40.2	- 51.4	JE CK
MCV	90.6		fL	82.5	- 96.5	JE CK
MCH	29.7		pg	27.1	- 34.3	JE CK
MCHC	32.8	LO	g/dL	33.0	- 35.0	JE CK
RDW	14.0		%	12.0	- 14.0	JE CK
PLT	144		10^3/uL	130	- 374	JE CK
MPV	9.4		fL	6.9	- 10.5	JE CK
RPR	Non-Reactive			NR		KS CK

-- End of Laboratory Report --

[redacted]

Reviewed by D. Olson, MD
Date: 12/30/03

[redacted]

S. Bakal, Med Tech

Name : MANSO-D, ABIMAEL
Register#: 09105-055
Printed : 12/24/2003 @ 19:32

Doctor : BEAM, MD
Location: FCI MCKEAN (MCK)
Sensitive L.O.U.

BP-S620.060 PATIENT PROBLEM LIST CDFRM
AUG 96

U.S. DEPARTMENT OF JUSTICE — FEDERAL BUREAU OF PRISONS

PROBLEM LIST

DATE NOTED	SIGNIFICANT DIAGNOSES	SIGNIFICANT OPERATIONS/ INVASIVE PROCEDURES	DATE
12-16-03	Asthma; SARC; GERD		
	C.P.; Scoliosis		
12-16-03	adjustment D/O		
	DSM IV Classification		
	Axis I.		
	Axis II:		
	Axis III:		

12/16/03
Allergies

ADVERSE / ALLERGIC DRUG REACTIONS
(If none, record "No Known Drug Allergies)

(+) RSA
(+) Food - Pasta
(+) Environment - SARC - Winter/Fall

Patient Identification
(Name, Reg #, DOB)

(This form may be replicated via WP)

Abimel Manso

09105-055 11/25/66

Medication Summary Sheet

Ord.Date 12/17/03 — MANSO-DIAZ, ABIMAEL — B. SAYLOR
09105-055 — (0)Refills
Exp.Date 01/15/04 — INSTILL 3 TO 5 DROPS EACH EVENING FOR 5 DAYS
Rx # 160650 — CARBAMIDE PEROXIDE 6.5% OTIC — #1

Ord.Date 12/17/03 — MANSO-DIAZ, ABIMAEL — D. OLSON
09105-055 — (0)Refills
Exp.Date 01/22/04 — TAKE TWO TABLETS AT BEDTIME
Rx # 160664 — RANITIDINE 150 MG TAB — #60

Ord.Date 12/17/03 — MANSO-DIAZ, ABIMAEL — D. OLSON
09105-055 — (0)Refills
Exp.Date 01/20/04 — INHALE 2 PUFFS FOUR TIMES DAILY AS NEEDED
Rx # 160665 — ALBUTEROL INH 90MCG 17GM — #1

Ord.Date 12/17/03 — MANSO-DIAZ, ABIMAEL — D. OLSON
09105-055 — (0)Refills
Exp.Date 01/22/04 — INHALE 2 PUFFS FOUR TIMES DAILY
Rx # 160666 — TRIAMCINOLONE ACETONIDE 200MCG/INH MDI — #1

Ord.Date 12/22/03 — MANSO-DIAZ, ABIMAEL — S. LABROZZI
09105-055 — (3)Refills
Exp.Date 03/20/04 — TAKE ONE TABLET TWICE DAILY WITH FOOD OR MILK
Rx # 161231 — NAPROXEN SODIUM 550 MG TAB — #20

Ord.Date 01/23/04 — MANSO-DIAZ, ABIMAEL — H. BEAM,MD
09105-055 — (2)Refills
Exp.Date 04/21/04 — INHALE 2 PUFFS TWICE DAILY
Rx # 162360 — TRIAMCINOLONE ACETONIDE 200MCG/INH MDI — #1

Ord.Date 01/23/04 — MANSO-DIAZ, ABIMAEL — H. BEAM,MD
09105-055 — (2)Refills
Exp.Date 04/21/04 — INHALE 2 PUFFS FOUR TIMES DAILY AS NEEDED
Rx # 162361 — ALBUTEROL INH 90MCG 17GM — #1

Ord.Date 01/23/04 — MANSO-DIAZ, ABIMAEL — H. BEAM,MD
09105-055 — (2)Refills
Exp.Date 04/21/04 — TAKE ONE TABLET TWICE DAILY
Rx # 162362 — RANITIDINE 150 MG TAB — #60

Ord.Date 01/23/04 — MANSO-DIAZ, ABIMAEL — H. BEAM,MD
09105-055 — (4)Refills
Exp.Date 04/21/04 — TAKE ONE TABLET TWICE DAILY WITH FOOD OR MILK
Rx # 162359 — NAPROXEN SODIUM 550 MG TAB — #30

Ord.Date 04/01/04 — MANSO-DIAZ, ABIMAEL — S. LABROZZI
09105-055 — (0)Refills
Exp.Date 04/10/04 — TAKE ONE CAPSULE FOUR TIMES DAILY UNTIL FINISHED
Rx # 165416 — CEPHALEXIN 500 MG CAP — #20

Ord.Date 04/01/04 — MANSO-DIAZ, ABIMAEL — S. LABROZZI
09105-055 — (0)Refills
Exp.Date 04/30/04 — APPLT TO AFFECTED AREA EACH DAY OR TWICE DAILY **EXTERNAL USE ONLY**
Rx # 165417 — BACITRACIN OINT — #1

Ord.Date 04/21/04 — MANSO-DIAZ, ABIMAEL — H. BEAM,MD
09105-055 — (2)Refills
Exp.Date 07/19/04 — TAKE ONE TABLET TWICE DAILY
Rx # 166272 — RANITIDINE 150 MG TAB — #60

Ord.Date 04/21/04 — MANSO-DIAZ, ABIMAEL — H. BEAM,MD
09105-055 — (2)Refills
Exp.Date 07/19/04 — INHALE 2 PUFFS FOUR TIMES DAILY AS NEEDED
Rx # 166273 — ALBUTEROL INH 90MCG 17GM — #1

Ord.Date 04/21/04 — MANSO-DIAZ, ABIMAEL — H. BEAM,MD
09105-055 — (2)Refills
Exp.Date 07/19/04 — INHALE 2 PUFFS TWICE DAILY
Rx # 166274 — TRIAMCINOLONE ACETONIDE 200MCG/INH MDI — #1

Ord.Date 04/21/04 — MANSO-DIAZ, ABIMAEL — H. BEAM,MD
09105-055 — (2)Refills
Exp.Date 07/19/04 — TAKE ONE TABLET TWICE DAILY
Rx # 166275 — SULINDAC 150 MG TAB — #30

Ord.Date 05/10/04 — MANSO-DIAZ, ABIMAEL — S. LABROZZI
09105-055 — (0)Refills
Exp.Date 05/29/04 — TAKE ONE TABLET TWICE DAILY
Rx # 167120 — SULINDAC 150 MG TAB — #28

Ord.Date 05/10/04 — MANSO-DIAZ, ABIMAEL — S. LABROZZI
09105-055 — (0)Refills
Exp.Date 06/08/04 — INHALE 2 PUFFFS FOUR TIMES DAILY AS NEEDED
Rx # 167121 — ALBUTEROL INH 90MCG 17GM — #1

Ord.Date 05/10/04 — MANSO-DIAZ, ABIMAEL — S. LABROZZI
09105-055 — (0)Refills
Exp.Date 06/08/04 — INHALE 3 PUFFS TWICE DAILY
Rx # 167122 — TRIAMCINOLONE ACETONIDE 200MCG/INH MDI — #1

Ord.Date 05/10/04 — MANSO-DIAZ, ABIMAEL — S. LABROZZI
09105-055 — (0)Refills
Exp.Date 05/29/04 — TAKE ONE TABLET TWICE DAILY
Rx # 167123 — RANITIDINE 150 MG TAB

BP-S619.060 IMMUNIZATION RECORD CDFRM
AUG 96

U.S. DEPARTMENT OF JUSTICE — FEDERAL BUREAU OF PRISONS

TETANUS TOXOIDS

DATE	MFG'R	LOT #	EXP. DATE	SITE	DOSE/ ROUTE	PROVIDER	INSTITUTION

TUBERCULIN TESTS

DATE GIVEN	MFG'R	LOT #	EXP. DATE	SITE	DOSE/ ROUTE	PROVIDER/ INSTITUTION	DATE READ	RESULTS (MM)	READ BY
11/21/03						INS HSD BUFFALO		0	

Patient Identification
(Name, Reg #)

(This form may be replicated via WP)

Abimael Manso

09105-055

000028

PRINTED ON RECYCLED PAPER

MEDICAL RECORD — REPORT OF MEDICAL EXAMINATION

DATE OF EXAM: 12.17.03

1. LAST NAME–FIRST NAME–MIDDLE NAME: Manso Abimael
2. IDENTIFICATION NUMBER: 09105-055
3. GRADE AND COMPONENT OR POSITION: I/M
4. HOME ADDRESS (Number, street or RFD, city or town, state and ZIP code): X 444 Fargo Ave Buffalo, ny 14213
5. EMERGENCY CONTACT (Name and address of contact): X Nancy Manso 444 Fargo Ave Buffalo ny 14213
6. DATE OF BIRTH: 11/25/66
7. AGE: 37
8. SEX: ☐ FEMALE ☒ MALE
9. RELATIONSHIP OF CONTACT: X wife
10. PLACE OF BIRTH: X Puerto Rico
11. RACE: ☐ WHITE ☐ BLACK ☐ AMERICAN INDIAN/ALASKA NATIVE ☒ HISPANIC WHITE ☐ HISPANIC BLACK ☐ ASIAN/PACIFIC ISLANDER
12a. AGENCY: BOP DOT
12b. ORGANIZATION UNIT: FCI McKean
13. TOTAL YEARS GOVERNMENT SERVICE: a. MILITARY: N/A b. CIVILIAN: N/A
14. NAME OF EXAMINING FACILITY OR EXAMINER, AND ADDRESS: FCI McKean, P.O. Box 5000, Bradford, PA 16701
15. RATING OR SPECIALTY OF EXAMINER: family practice
16. PURPOSE OF EXAMINATION: A+D

17. CLINICAL EVALUATION

NORMAL	(Check each item in appropriate column, enter "NE" if not evaluated.)	ABNORMAL	NORMAL	(Check each item in appropriate column, enter "NE" if not evaluated.)	ABNORMAL
✓	A. HEAD, FACE, NECK AND SCALP		NE	O. PROSTATE (Over 40 or clinically indicated)	
✓	B. EARS-GENERAL (INTERNAL CANALS) (Auditory acuity under items 39 and 40)		NE	P. TESTICULAR	
✓	C. DRUMS (Perforation)		NE	Q. ANUS AND RECTUM (Hemorrhoids, Fistulae) (Hemocult Results)	
✓	D. NOSE		✓	R. ENDOCRINE SYSTEM	
✓	E. SINUSES		✓	S. G-U SYSTEM	
✓	F. MOUTH AND THROAT		✓	T. UPPER EXTREMITIES (Strength, range of motion)	
✓	G. EYES-GENERAL (Visual acuity and refraction under items 28, 29, and 36)		✓	U. FEET	
✓	H. OPHTHALMOSCOPIC		✓	V. LOWER EXTREMITIES (Except feet) (Strength, range of motion)	
✓	I. PUPILS (Equality and reaction)		✓	W. SPINE, OTHER MUSCULOSKELETAL	
✓	J. OCULAR MOTILITY (Associated parallel movements nystagmus)		✓	X. IDENTIFYING BODY MARKS, SCARS, TATTOOS	
✓	K. LUNGS AND CHEST		✓	Y. SKIN, LYMPHATICS	
✓	L. HEART (Thrust, size, rhythm, sounds)		✓	Z. NEUROLOGIC (Equilibrium tests under item 41)	
✓	M. VASCULAR SYSTEM (Varicosities, etc.)		✓	AA. PSYCHIATRIC (Specify any personality deviation)	
✓	N. ABDOMEN AND VISCERA (Include hernia)		N/A	BB. BREASTS	
			N/A	CC. PELVIC (Females only)	

NOTES: (Describe every abnormality in detail. Enter pertinent item number before each comment. Continue in item 42 and use additional sheets if necessary)

B: cerebral palsy; ↓ use of (L) ↑ nystagmus

V: ↓ DTX (L) ↓ extremity ☐ ↓ sensation, ↓ strength

T: (L) ↑ extremity ☐ paralysis

U - Surgeries on toes in feet (3; last one done 2002,

W - scoliosis + accident. I/M states trauma to back from fall - usually uses a wheelchair, ↓ left ↓ right

X - tattoos - (R) leg, (R) biceps, (R) back; scars (L) foot

18. DENTAL (Place appropriate symbols, shown in examples, above or below number of upper and lower teeth)

Restorable Teeth: 32 31 30 (0); Non-restorable teeth: 32 31 30 (/); Missing Teeth: 32 31 30 (X); Replaced by Dentures: 32 31 30 (X X X / X X X); Fixed Partial Dentures: 32 31 30 (1 2 3 / 1 X 3)

RIGHT 1 2 3 4 5 6 7 8 | 9 10 11 12 13 14 15 16 LEFT
32 31 30 29 28 27 26 25 | 24 23 22 21 20 19 18 17

REMARKS AND ADDITIONAL DENTAL DEFECTS AND DISEASES

19. TEST RESULTS (Copies of results are preferred as attachments)

A. URINALYSIS: (1) SPECIFIC GRAVITY
(2) URINE ALBUMIN | (4) MICROSCOPIC
(3) URINE SUGAR
C. SYPHILIS SEROLOGY (Specify test used and results) | D. CBC | E. BLOOD TYPE AND Rh FACTOR | F. OTHER TESTS
B. CHEST X-RAY OR PPD (Place, date, film number and result)

NSN 7540-00-634-4038
88-126

STANDARD FORM 88 (Rev. 10-94)
Prescribed by GSA/ICMR FIRMR (41 CFR) 201-9.202-1

000029

NAME	IDENTIFICATION NUMBER	NO. OF SHEETS ATTACHED
Manso-Diaz, Abimael	09105-055	Ø

MEASUREMENTS AND OTHER FINDINGS

20. HEIGHT	21. WEIGHT	22. COLOR HAIR	23. COLOR EYES	24. BUILD	25. TEMPERATURE
69 1/2"	149 lbs.	Black	Brown	☑ SLENDER ☐ MEDIUM ☐ HEAVY ☐ OBESE	97°

26. BLOOD PRESSURE *(Arm at heart level)*

	A. SITTING	B. RECUMBENT	C. STANDING (5 mins.)
SYS.	120		
DIAS.	78		

27. PULSE *(Arm at heart level)*

A. SITTING	B. RECUMBENT	C. STANDING (3 mins.)	D. AFTER EXERCISE	E. 2 MINS. AFTER
AP -	68	R - 17		

28. DISTANT VISION		29. REFRACTION			30. NEAR VISION	
RIGHT 20/ 25	CORR. TO 20/	BY	S.	CX	CORR. TO	BY
LEFT 20/ 25	CORR. TO 20/	BY	S.	CX	CORR. TO	BY

31. HETEROPHORIA *(Specify distance)*

ESO	EXO	R.H.	L.H.	PRISM DIV.	PRISM CONV. CT	PC	PD

32. ACCOMMODATION		33. COLOR VISION *(Test used and result)*	34. DEPTH PERCEPTION *(Test used and score)*	UNCORRECTED
RIGHT WNL	LEFT WNL	Ishihara: Pass		CORRECTED
35. FIELD OF VISION		**36. NIGHT VISION** *(Test used and score)*	**37. RED LENS TEST**	**38. INTRAOCULAR TENSION**
RIGHT WNL	LEFT WNL			RIGHT LEFT

39. HEARING			40. AUDIOMETER									41. PSYCHOLOGICAL AND PSYCHOMOTOR *(Tests used and score)*
RIGHT WV	/15 SV	/15		250 256	500 512	1000 1024	2000 2048	3000 2896	4000 4096	6000 6144	8000 8192	
LEFT WV	/15 SV	/15	RIGHT									
			LEFT									

42. NOTES *(Continued)* AND SIGNIFICANT OR INTERVAL HISTORY

(1) ⊖ Head / Body lice
(2) ⊖ Exp to inf. disease; ⊖ STD'S
(3) ⊖ IVDA
(4) ⊖ Suicidal ideation

(Use additional sheets if necessary)

43. SUMMARY OF DEFECTS AND DIAGNOSES *(List diagnoses with item numbers)*

37 yo old AA ♂ cerebral palsy and scoliosis. Pt states he takes meds for muscle spasm + pain - does not recall names. Pt states allergy to ASA - causes rash. Also states Pasta causes swelling of lips. ⊕ Smoker: 5 cig/day / 20 yrs.

1- A) cerebral palsy
2- B) scoliosis
3- C) Chronic pain

44. RECOMMENDATIONS - FURTHER SPECIALIST EXAMINATIONS INDICATED *(Specify)*

General clinic - cerebral palsy / pain

45A. PHYSICAL PROFILE

P	U	L	H	E	S

46. EXAMINEE *(Check)*

A. ☐ IS QUALIFIED FOR general duties - medically unassigned
B. ☑ IS NOT QUALIFIED FOR

45B. PHYSICAL CATEGORY

47. IF NOT QUALIFIED, LIST DISQUALIFYING DEFECTS BY ITEM NUMBER

1, 2, 3

A	B	C	E

48. TYPED OR PRINTED NAME OF PHYSICIAN	SIGNATURE
Bonnie Seglen NPC	Bonnie Seglen NPC
49. TYPED OR PRINTED NAME OF PHYSICIAN	SIGNATURE
D. Olson, MD	D. Olson MD
50. TYPED OR PRINTED NAME OF DENTIST OR (Clinical Director which)	SIGNATURE
TYPED OR PRINTED NAME OF REVIEWING OFFICER OR APPROVING AUTHORITY	SIGNATURE

000030

MEDICAL HISTORY REPORT

(THIS INFORMATION IS FOR OFFICIAL AND MEDICALLY CONFIDENTIAL USE ONLY AND WILL NOT BE RELEASED TO UNAUTHORIZED PERSONS)

1. LAST NAME—FIRST NAME—MIDDLE NAME	2. REGISTER NUMBER
[redacted]	09[redacted]

3. PURPOSE OF EXAMINATION	4. DATE OF EXAMINATION	5. EXAMINING FACILITY
Intake	12-16-03	FCI McKean

6. STATEMENT OF EXAMINEE'S PRESENT HEALTH AND MEDICATIONS CURRENTLY USED *(Follow by description of past history, if complaint arises)*

37 y/o H ~~09~~ & mult. Medical issues & [illegible]

allergy - ASA; (+) food - Pasta; (+) Environmental - Sand (dirty Pull)

7. HAVE YOU EVER *(Please check each item)*

YES	NO	(Check each item)
	✓	Lived with anyone who had tuberculosis
	✓	Coughed up blood
	✓	Bled excessively after injury or tooth extraction
	✓	Attempted suicide
	✓	Been a sleepwalker

8. DO YOU *(Please check each item)*

YES	NO	(Check each item)
✓		Wear glasses or contact lenses
✓		Have vision in both eyes
	✓	Wear a hearing aid
	✓	Stutter or stammer habitually
	✓	Wear a brace or back support

9. HAVE YOU EVER HAD OR HAVE YOU NOW *(Please check at left of each item)*

YES	NO	DON'T KNOW	(Check each item)	YES	NO	DON'T KNOW	(Check each item)	YES	NO	DON'T KNOW	(Check each item)
	✓		Scarlet fever				Adverse reaction to serum drug		✓		Epilepsy or fits
	✓		Rheumatic fever				or medicine				Car, train, sea or air sickness
✓			Swollen or painful joints	✓			Broken bones	✓			Frequent trouble sleeping
✓			Frequent or severe headache		✓		Tumor, growth, cyst, cancer	✓			Depression or excessive worry
	✓		Dizziness or fainting spells				Rupture/hernia		✓		Loss of memory or amnesia
	✓		Eye trouble		✓		Piles or rectal disease				Nervous trouble of any sort
	✓		Ear, nose, or throat trouble				Frequent or painful urination				Periods of unconsciousness
			Hearing loss				Bed wetting since age 12		✓		Have you ever had
	✓		Chronic or frequent colds				Kidney stone or blood in urine		[illegible]		homosexual contact?
			Severe tooth or gum trouble				Sugar or albumin in urine		✓		Been exposed to AIDS
			Sinusitis				VD—Syphilis, gonorrhea, etc.		✓		Alcohol Use (Excessive)
			Hay Fever				Recent gain or loss of weight		✓		Drug Use/Addiction
			Head injury				Arthritis, Rheumatism, or Bursitis	✓			Marijuana
			Skin diseases				Bone, joint or other deformity				Cocaine
			Thyroid trouble				Lameness				Heroin
			Tuberculosis				Loss of finger or toe				L.S.D.
✓			Asthma	✓			Painful or "Trick"shoulder or elbow				Amphetamines
			Shortness of breath				Recurrent back pain		✓		Others: (Specify)
			Pain or pressure in chest				"Trick" or locked knee				
			Chronic cough				Foot trouble				Alcohol or drug
			Palpitation or pounding heart				Neuritis				Withdrawal Problems
			Heart trouble				Paralysis (include infantile)				
			High or low blood pressure								
		✓	Cramps in your legs								
			Frequent indigestion								
			Stomach, liver, or intestinal trouble								
			Gall bladder trouble or gallstones								
			Jaundice or hepatitis								

10. FEMALES ONLY HAVE YOU EVER

			Been treated for a female disorder
			Had a change in menstrual pattern
			ARE YOU PREGNANT
			SUSPECT YOU ARE PREGNANT

11. WHAT IS YOUR USUAL OCCUPATION?

12. ARE YOU (Check one)
☐ Right handed ☐ Left handed

Robert E. [illegible]

CHECK EACH ITEM YES OR NO EVERY ITEM CHECKED YES MUST BE FULLY EXPLAINED IN BLANK SPACE BELOW

YES	NO		YES	NO	
		13. Have you been refused employment or been unable to hold a job or stay in school because of: A. Sensitivity to chemicals, dust, sunlight, etc.			18. Have you ever had any illness or injury other than those already noted? *(If yes, specify when, where, and give details.)*
		B. Inability to perform certain motions.			19. Have you consulted or been treated by clinics, physicians, healers, or other practitioners within the past 5 years for other than minor illnesses? *(If yes, give complete address of doctor, hospital, clinic, and details.)*
		C. Inability to assume certain positions.			
		D. Other medical reasons *(If yes, give reasons.)*			20. Have you ever been rejected for military service because of physical, mental, or other reason? *(If yes, give date, and reason, for rejections.)*
		14. Have you, ever been treated for a mental condition? *(If yes, specify when, where, and give details).*			
		15. Have you ever been denied life insurance? *(If yes, state reason and give details.)*			21. Have you ever been discharged from military service because of physical, mental, or other reasons? *(If yes, give date, reason, and type of discharge whether honorable, other than honorable, for unfitness or unsuitability.)*
		16. Have you had, or have you been advised to have, any operations? *(If yes, describe and give age at which occured.)*			
		17. Have you ever been a patient in any type of hospital? *(If yes, specify when, where, why, and name of doctor and complete address of hospital.)*			22. Have you ever received, is there pending, or have you applied for pension, or compensation for existing disability? *(If yes, specify what kind, granted by whom , and what amount, when, why.)*

EXPLANATION: (#13-22 ABOVE)

PMH - CP, MS Hernia, SARC, Scoliosis (COPD)
PSH - multiple orthopaedic for foot 2° CP

I certify that I have reviewed the foregoing information supplied by me and that it is true and complete to the best of my knowledge. I authorize any of the doctors, hospitals, or clinics mentioned above to furnish the Government a complete transcript of my medical record.

TYPED OR PRINTED NAME OF EXAMINEE	SIGNATURE

INTAKE SCREENING:

INMATE RECEIVED FROM: COURT ____ TRANSFER ____ P.V. ____

OTHER ____

MEDICAL STAFF'S COMMENTS AND OBSERVATIONS: PLEASE DIRECT YOUR ANSWERS TO MENTAL STATUS, POTENTIAL SUICIDE, APPEARANCE, CONDUCT, STATE OR CONSCIOUSNESS, RASHES, JAUNDICE, BRUISES AND/OR MARKS, SWEATING, BODY DEFORMITIES, ETC. NOTE OBSERVATIONS IN BLOCK 23 BELOW.

IF DRUGS HAVE BEEN USED, NOTE TYPE, HOW LONG, HOW MUCH, HOW OFTEN, HOW USED. WHEN WERE THEY LAST USED: HAVE THERE BEEN ANY PROBLEMS SINCE STOPPING THE USE OF DRUGS OR ALCOHOL? None

DOES PATIENT NEED TO BE SEEN IMMEDIATELY BY THE MEDICAL STAFF YES ____ NO X

WHAT ARRANGEMENTS HAVE BEEN MADE? Referral CCC to in 30 days

DUTY STATUS: TEMPORARY WORK ____ RESTRICTED X

GENERAL POPULATION X YES ____ NO Bottom Bunk Pass

TYPE AND EXTENT OF LIMITATION ____

23. Physician's summary and elaboration of all pertinent data *(Physician shall comment on all positive answers in item 6 through 22. Physician may develop by interview any additional medical history he deems important, and record any significant findings here.)*

37 y/o AA
Scoliosis
CP
MS Hernia
SARC
COPD
Adjustment D/O

FCI McKean
Date Inmate Received 12-16-03
Medical Hx. Reviewed Yes ✓ No ____
Evidence of Lice Yes ____ No ✓
Suicidal Thoughts Yes ____ No ✓
Recent Assault, Trauma or Abuse Yes ____ No ✓
S & S Infectious Dis. Yes ____ No ✓
Allergies to Meds. Yes ✓ No NKA
Medications Given? Yes ✓ No ____
MDI's x 2
Pills x 3

TYPED OR PRINTED NAME OF PHYSICIAN OR EXAMINER	DATE	SIGNATURE	NUMBER OF ATTACHED SHEETS
Robert E. Piotrowski, PA-C FCI McKean	12/16/03		

REVERSE

U.S. DEPARTMENT OF JUSTICE FEDERAL BUREAU OF PRISONS

(Medical staff shall complete this screening form on all arrivals to the Institution)

Institution	Date of Arrival	Time of Arrival
McKean	12/16/03	1300

Inmate's Name	Register Number
Moreno, Abimael	59105-055

M E D I C A L C L E A R A N C E

1. BP-149(60) reviewed? ☒ yes; ☐ no (Explain)

2. General Population Housing Approved? ☒ yes; ☐ no (Specify limitation or need)
   (+) Requires Bottom Bunk

3. Approved for Temporary Work Assignment? ☐ yes; ☒ no (Specify limitations or exclusions)
   2° #5 Below

4. For Holdovers: OK for Continued Transport? ☐ yes; ☐ no (Explain)
   N/A

5. Disabilities? ☒ yes ☐ no (If yes, enter code(s) into MDS)
   Code(s)
   Cerebral Palsy
   Scoliosis } Work restriction (+) Req. Bottom Bunk

6. Remarks:
   None

Medical Staff Signature	Date	Time
[signature]	Robert E. Piotrowski, PA-C FCI McKean	1305 hr

Medical Staff Title

Record Copy - Inmate Central File; copy - file
(This form may be replicated via WP)

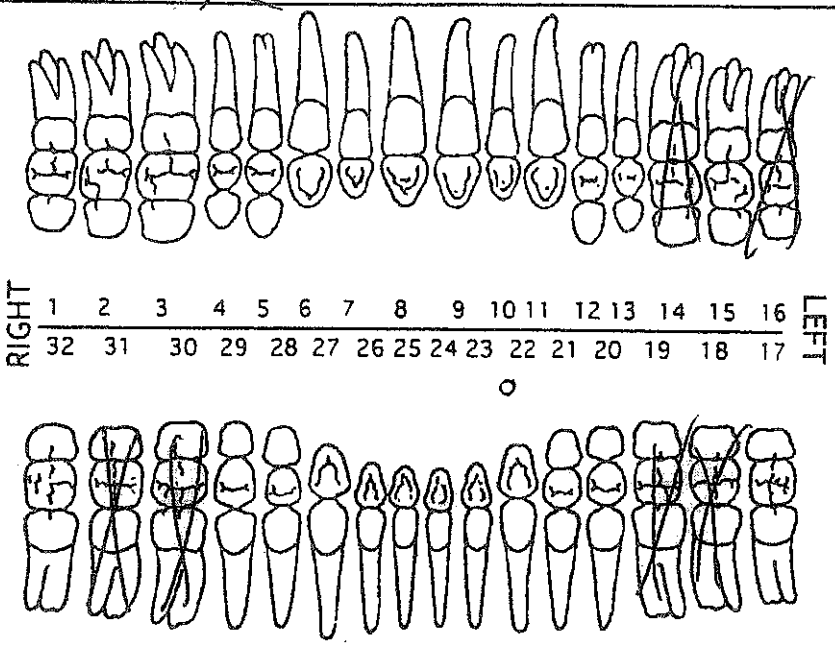
Replaces BP-354(60) of APRIL 1990 and BP-S354 of AUG 1994

PRINTED ON RECYCLED PAPER

BP-S618.060 CLINICAL DENTAL RECORD CDFRM
AUG 96

U.S. DEPARTMENT OF JUSTICE — FEDERAL BUREAU OF PRISONS

Examination: ☒ Screening ☐ Comprehensive ☐ Periodic



Occlusion: Class II

Oral Hygiene: Good (Fair) Poor

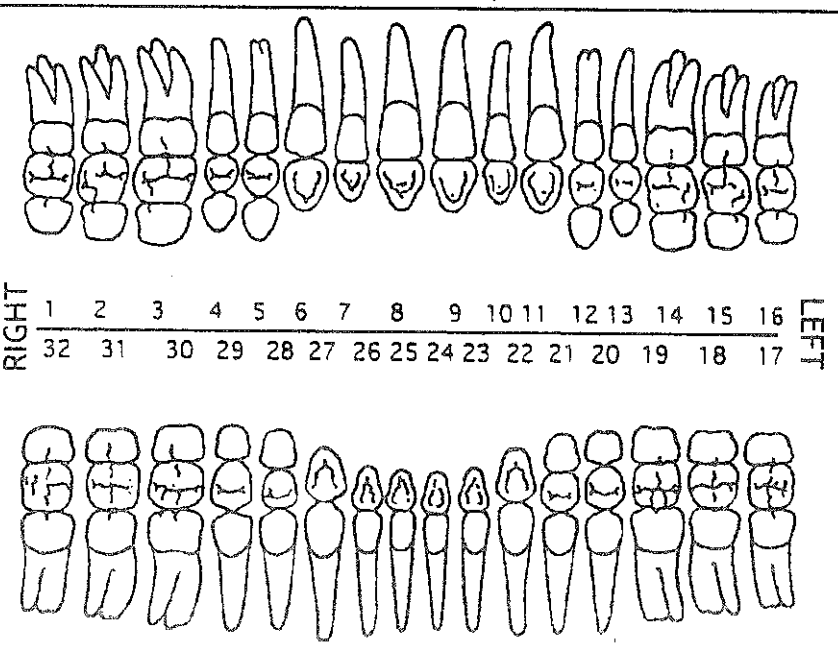
CPITN: 3 | 3 | 3 / 3 | 3 | 3

Head & Neck/Soft Tissue: STWNL

Additional Findings: Ant crowding
#8+9 discolored
heavy calc + stain

D: ___
M: ___
F: ___

Treatment Completed



Recommended Treatment Plan

☒ Radiographs

☐ Dental Prophylaxis
☒ Oral Hygiene Instruction

☐ Periodontal Evaluation 0 I II III

☐ Oral Surgical Procedures

☐ Endodontic

☐ Restorative

☐ Prosthodontic Evaluation

Patient Name: Manso Diaz, A. Number: 69105-055 Sex: M F Age: 37
11-25-66

Dentist Signature: Date: 2-20-04

W. K. Collins, DDS
CDO
FCI McKean

FCI McKean

Federal Bureau of Prisons Clinical Dental Records

Date/Time	#	Diagnosis - Treatment - Remarks
02-20-04 1100hrs		~~A&O Exam, Health History~~ reviewed. Sick call and ~~call-out procedures explained.~~ OHI given

J.L. Schroll, RDH RDH
FCI McKean

W. K. Collins, DDS
CDO
FCI McKean

Language template provided in Spa[redacted], or English

	YES	NO
1. Are your currently taking any medication? If so, what? Motrin 800 mg	✓	
2. Are you allergic to or have you had a reaction to any medication or drug? If so, what? Aspirin	✓	
3. Have you been under the care of a physician during the past two years? If so, why? I got cerebral palsy	✓	
4. Have you been hospitalized in the past two years? If so, why?		✓
5. Do you have or have you ever had a heart murmur or been treated for a heart condition?		✓
6. Have you ever been treated for a tumor, growth, or cancer?		✓
7. Have you ever had excessive or prolonged bleeding as a result of a medical condition or medication (ex. Hemophilia or blood thinners)?		✓
8. Do you have a latex allergy?		✓
9. Do you currently use tobacco products?	✓	
10. WOMEN ONLY: Are you pregnant?		

Check any of the following that you have had:

___ Congenital heart defects	✓ Arthritis	___ Epilepsy or seizures
___ Heart attack or heart problems	___ Artificial heart valve	___ Diabetes
___ Stroke	___ Hepatitis (☐A ☐B ☐C)	___ AIDS or HIV infection
___ Rheumatic fever	___ Any type of transplant	___ Emphysema
___ Mitral Valve Prolapse	___ Steroid treatment	___ Tuberculosis (TB)
___ Anemia (blood problems)	___ Sickle Cell Anemia	___ Psychiatric treatment
___ Thyroid problems	___ Angina	✓ Artificial joint
___ Chronic bronchitis	___ High blood pressure	___ Radiation therapy
___ STD (syphilis, gonorrhea, herpes)	___ Heart pacemaker	✓ Asthma
___ Angio edema	___ Glucose - 6-phosphate dehydrogenase deficiency	

Do you have any disease, condition, or problem not listed? _____

Check any of the following that you have had or applies to you:

___ Sensitive teeth	___ Unusual sounds while eating	___ Burning tongue
___ Bleeding gums	___ Snoring	___ Bad breath
___ Food impaction	___ Blisters on lips or mouth	___ Decayed teeth
___ Pain around ear	___ Clenching or grinding	___ Loose teeth
___ Tooth ache	___ Swelling or lumps in mouth/throat	___ Wear dentures
___ Wear partial dentures		

Printed Name: [redacted]	Signature: [redacted]
Reg. No.: [redacted]	Institution: FCI McKean
Date: 3/30/05	Updated:

This form may be replicated via WP!

FEDERAL CORRECTIONAL INSTITUTION HOSPITAL
FCI MCKEAN, PA

IDLE, CONVALESCENT AND CHANGE IN WORK CLASSIFICATION STATUS

TO: ALL CONCERNED UNIT: _____ DATE: 12/17/03
INMATE'S NAME: Mamo, Ahmed DETAIL: _____ REG. NO. 09705-055

For Medical purposes, the inmate named above has been authorized the work and/or activity status listed below the reason(s) and the time shown.

MEDICAL CLASSIFICATION STATUS: (Check one and answer questions)

( ) IDLE: Reason _____ THRU 12 MIDNIGHT _____ 19___
( ) CONVALESCENCE: List any restricted activity for medical reasons. _____ THRU 12 MIDNIGHT _____ 19___
( ) RESTRICTED DUTY: Specify exact restriction and reason. _____ THRU 12 MIDNIGHT _____ 19___
( ) TOTALLY DISABLED: (2) Med Unassigned
( ) FULL DUTY:

Physician or Physician Assistant

DEFINITIONS AND INSTRUCTIONS

IDLE STATUS - temporary disability not to exceed three days duration including weekends and holidays. Restricted to room except for meals, barbering, religious services, sick call, visits and call outs. No recreation activity.
CONVALESCENT STATUS - Recovery period for operation, injury, or serious illness. Not less than four days and not to exceed thirty days, subject to renewal. Excused from work and may not participate in any recreational activities outside the unit.
RESTRICTED DUTY - Restricted from specific activities because of physical or mental handicap. List handicap, work limitation and time period, either specific date or indefiite.
TOTALLY DISABLED - Totally unemployable and unassigned because of mental or physical reasons. Condition generally expected to last indefinitely.
FULL DUTY - No work restrictions because of physical, medical or mental disability.

FEDERAL CORRECTIONAL INSTITUTION HOSPITAL
FCI MCKEAN, PA

IDLE, CONVALESCENT AND CHANGE IN WORK CLASSIFICATION STATUS

TO: ALL CONCERNED UNIT: BB DATE: 12/22/03
INMATE'S NAME: MANSO-DIAZ, A. DETAIL: unassigned REG. NO. 09105-055

For Medical purposes, the inmate named above has been authorized the work and/or activity status listed below the reason(s) and the time shown.

MEDICAL CLASSIFICATION STATUS: (Check one and answer questions)

( ) IDLE: Reason _____ THRU 12 MIDNIGHT _____ 19___
( ) CONVALESCENCE: List any restricted activity for medical reasons. _____
_____ THRU 12 MIDNIGHT _____ 19___
( ) RESTRICTED DUTY: Specify exact restriction and reason. _____
_____ THRU 12 MIDNIGHT _____ 19___
( ) TOTALLY DISABLED:
( ) FULL DUTY:

Soft Shoe (Sneaker) PASSy 6 months

Steven Lanfazzi, PA-C
Physician Assistant
Physician or Physician Assistant

DEFINITIONS AND INSTRUCTIONS

IDLE STATUS - temporary disability not to exceed three days duration including weekends and holidays. Restricted to room except for meals, barbering, religious services, sick call, visits and call outs. No recreation activity.
CONVALESCENT STATUS - Recovery period for operation, injury, or serious illness. Not less than four days and not to exceed thirty days, subject to renewal. Excused from work and may not participate in any recreational activities outside the unit.
RESTRICTED DUTY - Restricted from specific activities because of physical or mental handicap. List handicap, work limitation and time period, either specific date or indefilte.
TOTALLY DISABLED - Totally unemployable and unassigned because of mental or physical reasons. Condition generally expected to last indefinitely.
FULL DUTY - No work restrictions because of physical, medical or mental disability.

FEDERAL CORRECTIONAL INSTITUTION HOSPITAL
FCI MCKEAN, PA

IDLE, CONVALESCENT AND CHANGE IN WORK CLASSIFICATION STATUS

TO: ALL CONCERNED UNIT: BB DATE: 12-17-03
INMATE'S NAME: Manso-Diaz, Abraham DETAIL: unassigned REG. NO. 09105-055

For Medical purposes, the inmate named above has been authorized the work and/or activity status listed below the reason(s) and the time shown.

MEDICAL CLASSIFICATION STATUS: (Check one and answer questions)

( ) IDLE: Reason _____ THRU 12 MIDNIGHT _____ 19___
( ) CONVALESCENCE: List any restricted activity for medical reasons. _____
_____ THRU 12 MIDNIGHT _____ 19___
( ) RESTRICTED DUTY: Specify exact restriction and reason. _____
_____ THRU 12 MIDNIGHT _____ 19___
(X) TOTALLY DISABLED: unlimited use of wheelchair
( ) FULL DUTY:

Dr. Adam PhD
Bonnie Snyder NP-C
Physician or Physician Assistant

DEFINITIONS AND INSTRUCTIONS

IDLE STATUS - temporary disability not to exceed three days duration including weekends and holidays. Restricted to room except for meals, barbering, religious services, sick call, visits and call outs. No recreation activity.
CONVALESCENT STATUS - Recovery period for operation, injury, or serious illness. Not less than four days and not to exceed thirty days, subject to renewal. Excused from work and may not participate in any recreational activities outside the unit.
RESTRICTED DUTY - Restricted from specific activities because of physical or mental handicap. List handicap, work limitation and time period, either specific date or indefilte.
TOTALLY DISABLED - Totally unemployable and unassigned because of mental or physical reasons. Condition generally expected to last indefinitely.
FULL DUTY - No work restrictions because of physical, medical or mental disability.

FEDERAL CORRECTIONAL INSTITUTION HOSPITAL
FCI MCKEAN, PA

IDLE, CONVALESCENT AND CHANGE IN WORK CLASSIFICATION STATUS

TO: ALL CONCERNED UNIT: AA DATE: 3/11/04
INMATE'S NAME: MANSO, A DETAIL: unassigned REG. NO. 09105-055

For Medical purposes, the inmate named above has been authorized the work and/or activity status listed below the reason(s) and the time shown.

MEDICAL CLASSIFICATION STATUS: (Check one and answer questions)

( ) IDLE: Reason _____ THRU 12 MIDNIGHT _____ 19___
( ) CONVALESCENCE: List any restricted activity for medical reasons. _____ THRU 12 MIDNIGHT _____ 19___
( ) RESTRICTED DUTY: Specify exact restriction and reason. _____ THRU 12 MIDNIGHT _____ 19___
( ) TOTALLY DISABLED:
( ) FULL DUTY:
Arm Sling x 2 weeks

Steven Labrozzi, PA
Physician Assistant
Physician or Physician Assistant

DEFINITIONS AND INSTRUCTIONS

IDLE STATUS - temporary disability not to exceed three days duration including weekends and holidays. Restricted to room except for meals, barbering, religious services, sick call, visits and call outs. No recreation activity.
CONVALESCENT STATUS - Recovery period for operation, injury, or serious illness. Not less than four days and not to exceed thirty days, subject to renewal. Excused from work and may not participate in any recreational activities outside the unit.
RESTRICTED DUTY - Restricted from specific activities because of physical or mental handicap. List handicap, work limitation and time period, either specific date or indefinite.
TOTALLY DISABLED - Totally unemployable and unassigned because of mental or physical reasons. Condition generally expected to last indefinitely.
FULL DUTY - No work restrictions because of physical, medical or mental disability.

FEDERAL CORRECTIONAL INSTITUTION HOSPITAL
FCI MCKEAN, PA

IDLE, CONVALESCENT AND CHANGE IN WORK CLASSIFICATION STATUS

TO: ALL CONCERNED UNIT: A-A DATE: 1/22/04
INMATE'S NAME: Ishmael Manso DETAIL: Unassigned REG. NO. 09105-055

For Medical purposes, the inmate named above has been authorized the work and/or activity status listed below the reason(s) and the time shown.

MEDICAL CLASSIFICATION STATUS: (Check one and answer questions)

( ) IDLE: Reason _____ THRU 12 MIDNIGHT _____ 19___
( ) CONVALESCENCE: List any restricted activity for medical reasons. Scoliosis Corset THRU 12 MIDNIGHT _____ 19___
( ) RESTRICTED DUTY: Specify exact restriction and reason. _____ THRU 12 MIDNIGHT _____ 19___
( ) TOTALLY DISABLED: Please find the Thickert mattress
( ) FULL DUTY:
(Camp medium)

Physician or Physician Assistant

DEFINITIONS AND INSTRUCTIONS

IDLE STATUS - temporary disability not to exceed three days duration including weekends and holidays. Restricted to room except for meals, barbering, religious services, sick call, visits and call outs. No recreation activity.
CONVALESCENT STATUS - Recovery period for operation, injury, or serious illness. Not less than four days and not to exceed thirty days, subject to renewal. Excused from work and may not participate in any recreational activities outside the unit.
RESTRICTED DUTY - Restricted from specific activities because of physical or mental handicap. List handicap, work limitation and time period, either specific date or indefinite.
TOTALLY DISABLED - Totally unemployable and unassigned because of mental or physical reasons. Condition generally expected to last indefinitely.
FULL DUTY - No work restrictions because of physical, medical or mental disability.

BEAM, MD
FCI MCKEAN

BP-S148.055 **INMATE REQUEST TO STAFF** CDFRM
SEP 98

U.S. DEPARTMENT OF JUSTICE **FEDERAL BUREAU OF PRISONS**

TO: (Name and Title of Staff Member) Medical Records	DATE: 4/21/04
FROM: Abimael Marrero Diaz	REGISTER NO.: 09105-055
WORK ASSIGNMENT: UNNASSIGNED	UNIT: AA

SUBJECT: (Briefly state your question or concern and the solution you are requesting. Continue on back, if necessary. Your failure to be specific may result in no action being taken. If necessary, you will be interviewed in order to successfully respond to your request.)

I would like to have copy of my Medical Records Please the HIV test result & the last Appointment with Dr. Bean I need those copy to take it with me Home the last visit with Dr Bean was on 4/21/04

Thank you

(Do not write below this line)

DISPOSITION:

See Attached (1)
HIV tst results are non-releasable while you are in BOP custody.

FCI Mr Kean

Signature Staff Member

Date 4/22/04

Record Copy - File; Copy - Inmate
(This form may be replicated via WP)

This form replaces BP-148.070 dated Oct 86 and BP-S148.070 APR 94

Printed on Recycled Paper

000040

BP-S489.061 HIV COUNSELING DOCUMENTATION CDFRM
APR 99
U.S. DEPARTMENT OF JUSTICE FEDERAL BUREAU OF PRISONS

Directions:

Use the following criteria to counsel the patient who is tested for the HIV antibody. Check off each item as they are discussed. Write NA beside any item that is inappropriate to the situation. Secure this form until pre- and post-test counseling is completed, then file in the patient's chart, documenting in progress notes that counseling was completed as provided on forms BP-490(61), BP-491(61), and BP-492(61), as appropriate.

PRE-TEST:

✓ 1. Explain purpose of session.

✓ 2. Explain confidentiality.

✓ 3. Explain HIV antibody test.

- ✓ a. What AIDS is
- ✓ b. What the test is
- ✓ c. Test Procedure
- ✓ d. Meaning of test results
- ✓ e. Inability of detecting early infection (false negatives)
- ✓ f. Possible need for additional testing
- ✓ g. Complications and consequence of a positive test.

✓ 4. List risk factors.

✓ 5. Explain precautions for persons with possible exposure.

✓ 6. Obtain informed consent (when applicable).

✓ 7. Risk Reduction Behaviors. Educational material given.

✓ 8. Patient Reactions/Comments.

Inmate Name MANSO-DIAZ, ABimaeL	Register No. 09105-055

I understand the above information about the HIV test.

Signature of Inmate [signature]	Signature of Staff Counselor [signature]
Date: 4/14/04	

File in the Medical Record: Section 6.

BP-S148.055 INMATE REQUEST TO STAFF CDFRM
SEP 98

U.S. DEPARTMENT OF JUSTICE — FEDERAL BUREAU OF PRISONS

TO: (Name and Title of Staff Member) Medical Records	DATE: 4/11/04
FROM: Abimael MANSO DIAZ	REGISTER NO.: 09105-055
WORK ASSIGNMENT: Unassigned	UNIT: AA

SUBJECT: (Briefly state your question or concern and the solution you are requesting. Continue on back, if necessary. Your failure to be specific may result in no action being taken. If necessary, you will be interviewed in order to successfully respond to your request.)

I Need Copy of my last visit with the PA on 4/8/04
And 4/1/04 of my Medical Records

Thank you

(Do not write below this line)

DISPOSITION:

See Attached
(2) pp.

FCI McKean

Signature Staff Member

Date 4/13/04

Record Copy - File; Copy - Inmate
(This form may be replicated via WP)

This form replaces BP-148.070 dated Oct 86
and BP-S148.070 APR 94

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0000042

BP-S148.055 **INMATE REQUEST TO STAFF** CDFRM
SEP 98

U.S. DEPARTMENT OF JUSTICE **FEDERAL BUREAU OF PRISONS**

TO: (Name and Title of Staff Member)	DATE:
Medical Records	3/15/04
FROM:	REGISTER NO.:
Abimael Manso Diaz	09105-055
WORK ASSIGNMENT:	UNIT:
Med Unassigned	AA

SUBJECT: (Briefly state your question or concern and the solution you are requesting. Continue on back, if necessary. Your failure to be specific may result in no action being taken. If necessary, you will be interviewed in order to successfully respond to your request.)

I need copy of my medical Records

Thank you

(Do not write below this line)

DISPOSITION:

See attached pages (8)

FCI McKean

Signature Staff Member	Date
3/15/04	

Record Copy - File; Copy - Inmate
(This form may be replicated via WP)

This form replaces BP-148.070 dated Oct 86 and BP-S148.070 APR 94

Printed on Recycled Paper

Inmate Sick Call Sign-Up Sheet
(Formulario de Registro para Atencion Medica de Consultorio)

INSTRUCTIONS
You must fill out this form completely, numbers 1-9:
(Debe de llanar este formulario completamente, numeros 1-9.)

1. Name: Abimael Manso Diaz
(Nombre)
2. Reg. Number: 09105-055
(Numero de Registro)
3. Date: 1/21/04
(Fecha)
4. Housing unit and Unit Team: AA TEAM: A B C D
(unidad y equipo de la unidad)
5. Complaint, What is your problem?
(Queja). (Cual es su problema?)
Spinal problem. WANTS SPECIAL MATTRESS.

6. How long have you had this problem?
(Durante cuante tiempo ha tenido este problema?)
Days ____ Months ____ Years 10
(Dias) (Meses) (Anos)
7. Are you on any medication(s) at present? Yes ____ No ____
(Esta usted tomando alguna(s) medicinas actualmente?)

8. Have you purchased Over-the-Counter Medications from Commissary?
(Ha comprado medicinas non-prescipcion en la Comisaria?)
Yes ____ No ✓

9. Signature [signature]
(Firma)

TO BE COMPLETED BY HEALTHCARE STAFF TRIAGE PERSONNEL:

1-27-04

10. Date seen: Mr. Manso,
11. Time seen: Mr Kindervater, your unit manager, called
12. Subjective: me late yesterday afternoon. He told me you have two mattresses on your bed. If these two mattresses aren't helping you,
13. Objective: Temp: ____ Pulse ____ Respirations ____ B/P ____
14. Appointment Date: ____ Appointment Time ____
15. Triage Personnel's Signature: ____

[illegible]